LOS ANGELES COUNTY
COMMISSION ON HIV HEALTH SERVICES (CHHS)

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COMMISSION MEETING

Minutes

January 9, 2003

Approved, 2/13/03

MEMBERS PRESENT	MEMBERS ABSENT	**OTHERS PRESENT**	**OAPP STAFF PRESENT**
Al Ballesteros, *Co-Chair*	Adrian Aguilar	Cinderella Barrios-Cernik	Libby Boyce
Carrie Broadus	Carla Bailey	Gordon Bunch	Patricia Gibson
Robert Butler	Nettie DeAugustine	Pedro Chavez	Alan Kurz
John Caranto	Nancy Eugenio	Oscar De La O	Jane Nachazel
Richard Corian	Genevieve Clavreul	John Griggs	Craig Vincent-Jones
Richard Eastman	Rebecca Johnson-Heath	Elliot Johnson	Dave Young
Gunther Freehill	Mary Lucey	Jennifer Karcher	
Danielle Glenn-Rivera	Elizabeth Marte	Ramon Leow	
Alexander Gonzales	Vicky Ortega	Jose Medina	
Richard Hamilton	Dana Pierce-Hedge (E)	Taijonee Magee	
Marc Haupert	Alexis Rivera	Sergio Navarro	
Charles Henry	Vanessa Talamantes	Kay Ostberg	
Howard Jacobs	Chris Wade	Dave Schwartz	
Wilbert Jordan	Rodolfo Zamudio	James Stewart	
Marcy Kaplan		Rob Thrash, IV	
Brad Land		Jacey Weatherby	
Mike Lewis		Patricia Woody	
Anna Long			
Andrew Ma			
Edric Mendia			
Hernan Molina			
Chris Perry			
John Palomo			
Maria Robles			
Paul Scott			
Kevin Van Vreede			
Tom West			
Michael White Bear Claws			
Fariba Younai			

AGENDA ITEM	DISCUSSION	ACTION TAKEN
I. Call To Order	Mr. Ballesteros called the meeting to order at 9:30 a.m. Self-introductions were then made. He confirmed that a quorum was present.	
II. Approval of Agenda	Mr. Ballesteros suggested removing three items from the Co-Chairs' Report: Commission Membership Strategy, Latino Caucus/Task Force and the AMASSI Study. He said the items had been addressed at the Executive Committee. He continued that they had been delegated to committees for additional work. Mr. Ballesteros also recommended moving the summary approvals to the end of the agenda, in order to give people time to review them during meeting breaks.	**MOTION #1**: Approve the agenda as corrected ***(Passed by consensus)***.
III. Parliamentarian Report	Mr. Ballesteros noted that the Parliamentarian Report would be added as a standing item to the regular Commission meeting agenda. The item, he noted, gives James Stewart, the Commission's Parliamentarian, the chance to recap the prior meeting and offer continuous technical assistance and training.	
	Mr. Stewart noted that in an effort to use proper terminology, "breaks" would now be called "recesses", and the meeting would be "called to order", rather than "opened". He added that other similar enhancements would be incorporated as needed.	
	Mr. Stewart continued that he had heard discussions in which Commissioners commented that they did not like the way something was worded, but did nothing to modify the item. He counseled that if someone is not satisfied with an item, then the appropriate response would be to propose an amendment. Mr. Stewart noted that "friendly amendments" had been proposed at the last meeting, but there really is no such thing as a "friendly amendment." Any amendment is subject to a regular vote, and the person making the motion does not have any proprietary rights over amendments. The body as a whole retains all authority to accept or reject amendments.	
	Mr. West said that, at times, people have used the "friendly amendment" notion to clarify or strengthen a motion—for small changes. He asked how that could be accomplished in the future. Mr. Stewart responded that if the changes were obvious, then changes could be made by general consent. However, if there is not consensus, then the regular amendment process should be used.	
	Mr. Stewart also informed the Commission that abstentions are normally only asked for and recorded in roll call votes. He added that standard process for roll call votes is for the secretary to call for votes in alphabetical order. He added that the tally sheet could then be appended to the minutes. He suggested that the Commission follow that process.	

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	Mr. Jacobs asked if the person who originally makes the motion can modify it. Mr. Stewart replied that technically s/he can not. Once the chair restates the motion, he said, it belongs to the body as a whole. In practice, he said, a good clarification is generally permitted. Brad Land asked if a Commissioner making a motion could request assistance in making it; Mr. Stewart replied that s/he can. Mr. Freehill asked if a Commissioner can amend his/her own motion; Mr. Stewart responded in the affirmative.	
IV. Financial Orientation	Mr. White Bear Claws, Finance Committee Co-Chair, presented an introduction to the Commission's Finance Committee. He noted that, with greater independence, the Commission would be assuming greater financial oversight responsibilities. After Mr. White Bear Claws' called Commissioners' attention to the packet and introduced the other Finance Committee members, Andrew Ma continued the presentation.	
	Mr. Ma indicated that the goal of the orientation was to help Commissioners become familiar with their financial responsibilities—including budgeting and monitoring of expenditures—in order to make informed decisions about the allocation and reallocation of funds.	
	The basic responsibilities of the Finance Committee are to review the monthly financial expenditures, to make recommendations to the Commission regarding monitoring expenditures and reallocation of unspent funds, to develop a budget for the Commission and its staff operations, to oversee the Assessment of the Administrative Mechanism, to prepare a plan to evaluate and expand financial resources in response to HIV needs in Los Angeles County, and to provide financial training to Commissioners, providers and the public.	
	There are three major current tasks, he continued. One is the Assessment of the Administrative Mechanism (work was delayed last year due to delays in approving the purchase orders.) The Assessment of the Administrative Mechanism looks at how OAPP procures services (the RFP process), including administrative efficiency issues like the delays that occurred in the Commission's recent purchase order cycle. The goal is to identify and redress systemic problems that create unnecessary delays.	
	The second major task was to conduct the Financial Needs Assessment; work was also delayed due to challenges in the purchase order process. The Financial Needs Assessment is the component of the Comprehensive Care Plan that reviews the EMA's efforts to maximize the Ryan White CARE Act as funding of last resort. The Financial Needs Assessment identifies and plans how best to incorporate other resources.	

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	The third task, he continued, was the Budgeting Plan. This year, in addition to the basic budget for the Commission's regular activities, this year's plan must also address the transition plan for moving Commission support staff out of OAPP.	
	Directives were developed both at and following the Commission Retreat in November 2002. Of the seven directives, some are solely the responsibility of the Finance Committee while others are shared: **#9** Review and recommend maximum levels of available services in each service category (based on unit cost). *Finance* **#10** Devote capacity building funds to the development of adequate provider-level billing and access systems, with special emphasis focused on enhancing provider ability to access MediCal and Medicare funding for clients. *Finance* **#12** Study "best practices" for service system cost-efficiencies. *SOC, Finance* **#23** Dedicate capacity building funds to the development of increased dental services fairly distributed throughout the EMA, with more proactive support identifying traditional (Part F) and nontraditional (private) funding sources for the development of dental services *P&P, Finance* **#24** Limit any CARE Act-funded home health care services to high acuity (end-stage) clients. *Finance, P&P* **#26** Develop a better tracking system, eligibility requirements and standards for transportation services in order to improve/maximize cost efficiency and reduce waste of services. *SOC, Finance* **#27** Transition client advocacy services towards an enhanced benefits counseling focus, incorporating access to health insurance in client advocacy visits. *SOC, Finance*	
	The HRSA Title I application is normally due in September. For the Year 14 application, the budgeting process begins in January and February, as committees develop their budgets. Committees submit their requests to the Finance Committee for review. The Finance Committee forwards requests to the Executive Committee. The Commission has final review and approval.	
	Mr. Ma then introduced Dave Schwartz, the Budgeting and Financial Needs Assessment consultant, to provide more information on the budgeting process. Mr. Schwartz noted that he would be attending the January and February meetings for each of the committees to help them develop specific budgets.	
	He noted that budgeting guidelines were included in the orientation	

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	packet. Major classifications of expense are called budget categories, including equipment and supplies. Individual cost items within each category are budget line Items, like telephone expenses and postage.	
	In all cases, only expenses permitted by HRSA are eligible. Some types of expenses are never eligible, like the purchase or improvement of land. Other expenses, like training, are eligible for some purposes but not for others. For example, training costs associated with obtaining professsional licensure or meeting program licensure requirements is not HRSA eligible. HRSA also sets percentage limits on some types of expenses. Mr. Schwartz said he would assist committees in making the appropriate determinations.	
	Mr. Schwartz explained that the committee work plans would be reviewed to identify specific projects; both recurrent projects, like the Assessment of the Administrative Mechanism, and one-time projects. Once projects are identified, their costs are evaluated, and then detailed to the budget forms. Development of project costs will include ensuring appropriate justifications for the requests.	
	Mr. Schwartz noted the importance of presenting the committees' work to the Commission in March, so that revisions could be made as needed and a final budget prepared by July for use in preparation of the Title I application. He reiterated that this was the Year 14 budget timeline.	
	Brad Land asked how to determine the point at which a co-chair or committee needed to be concerned that a purchase order was being unduly delayed, and was requiring advocacy on its behalf. Mr. Ma replied that that topic was being addressed later in the presentation.	
	Mr. Ma noted that the budget forms in the orientation packet included the committee, the project, the budget period, the project description, the goals, the estimated staffing needs, the timeline, the contact person and phone number, and dates of submission and Commission approval. There are also space for final approval and comments to ensure appropriate follow-up. Budget categories, he continued, are travel, equipment, supplies, other and consultant/contractual. Mr. Ma pointed out the increased importance of accurately assessing costs necessary to support the Commission's work as it transitioned out of OAPP.	
	Mr. Schwartz indicated that Year 14 budget work would evolve on two tracks: 1) direct costs, i.e., project expenses requiring purchase orders or contracts of some sort, and 2) overall Commission support, regardless of whether it was through OAPP, another office or independent. Preliminary numbers for a fully staffed Commission have been developed and had already bee presented at the Commission Retreat.	

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	In response to a question, he noted that the overall staffing pattern would most likely be phased in. The concern for the Year 14 budget, he said, was to determine specific requirements for particular projects and for basic, month-to-month support. This would allow the Commission to prioritize staff allocation efforts, so the most critical positions are filled first. That is particularly important if not all the positions can be funded.	
	Michael Lewis, Finance Committee member, said that the committees were not expected to identify sophisticated resource needs. The emphasis was on fulfilling the needs of various projects. Patricia Gibson, OAPP Finance Director, added that the budget form only asked for general staffing needs, noting that the Commission had not yet matured enough to provide more detail. Mr. Jacobs added that as the Commission structure develops, how needs are met will shift, so that what started as a consultant work may become a staff function. The process would be ongoing during the transition period, he said. Mr. Schwartz noted that one of his charges as the budgeting consultant is to advise individual committees, as well as the Finance and Executive Committees, on the most cost-effective ways of addressing needs.	
	Mr. Henry added that it would probably be uncertain how long this parallel form of budgeting process will continued, acknowledging that it will be necessary until the Board of Supervisors (BOS) decides where Commission staffing support will be located and which items will be actually allocated. There had been, he noted, delays even in moving forward the recommendation to separate from OAPP, even though it was consistent with HRSA guidance. A staffing pattern has been adopted by the Commission, he said, which, at least, serves as a negotiation point. He recommended that the Commission Co-Chairs assign the Commission separation negotiations to either the Executive or another committee. For example, he said, the Chief Administrative Office (CAO) had been assigned to begin the review process. Recommendations would follow, and they probably would be subject to additional negotiation with the office that is going to house Commission support. He felt a specific committee assignment was important to ensure progress.	
	Mr. Lewis said he understood there was a July 1st deadline for the Commission to separate. Mr. Henry responded that the CAO was to report to the BOS with a recommendation by that time. Based on his experience with the County, he anticipated that significant time would elapse before the separation actually occurred. The BOS would review the recommendations before approving them. Once approved, someone would be assigned in the Executive Office to determine item allocations before	

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	recruitment could begin. The entire process was one of negotiation, he said. That was why he strongly recommended that a committee be charged with actively following the process.	
	Mr. Jacobs continued that when reviewing budget requests, the Finance Committee would be looking at questions such as are expenses reasonable and realistic, e.g., if producing a pamphlet, are reproduction costs sufficient? Are there more cost efficient ways of accomplishing the project? Does the justification explain the expenditures? Will the expenditures achieve the stated goals? Is the project realistic, reasonable and sustainable? How is the project implemented by staff or consultant and is the choice of staff or consultant appropriate? Are funds drawn from the appropriate line item? What is the impact of the request on the total Commission budget? Are expenses allowable by HRSA or the County? Is the work within the charge of the committee making the request? Are the goals and objectives in concert with those of HRSA, the County and the Commission?	
	Mr. Jacobs continued that Finance would review quarterly expenditure statements. Committees can modify their line items over the course of the year; as long as the total approved budget doesn't change, line items can be modified up to 30%. Unanticipated expenses must be submitted to the Finance Committee.	
	Regarding Year 13, Mr. Ma said, the award had not yet been released, but was anticipated in mid-February to early March. If the award is smaller than requested, downward adjustments would be needed. If the award is larger, the Commission could allocate the additional funds as preferred. Project requests would be due March 7th, he continued, for final review by Finance on March 27th and April Commission presentation. Final revisions would be done in mid-April.	
	As noted earlier, Year 14 budget work was beginning with Mr. Schwartz' assistance. That work, Mr. Ma went on, would be presented at the March priority-setting meeting.	
	Ms. Gibson reviewed the Title I and Title II monthly reports regularly presented in the Commission's meeting packets. She noted that the report is broken down into service categories approved for funding by the Commission. Mr. Henry noted that the delinquency column enhanced planning as delinquent invoices in one category could balance needs assessed in categories with current numbers. Mr. Lewis commented that most common reasons for delinquency were coordination associated with starting a new program and lack of perceived urgency associated with publicly funded programs.	

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	Ms. Gibson noted that contractual obligations for service categories are generally higher than Title I funding allocations. She elaborated that providers generally underspend grants by 7-10%, so contracted amounts are purposely set to encourage ultimate maximization of Title I funds received. In addition, there are generally State and County funds available to cover any discrepancies.	
	Maria Robles then provided an overview of the procurement process. She noted that the six basic steps were discussed in the finance orientation packet: **Step 1**: ***Budget Request Presentation***: committees detail services desired and present the request to the Executive Committee. *Approval takes 1-3 months without rewriting; longer if rewritten*. **Step 2**: ***Scope Of Work (SOW) Development***: detailed project information to County ISD for the construction of RFPs. **Step 3**: ***RFP Solicitation***: qualified proposals will be forwarded to the Commission for review and scoring. *RFP creation, solicitation and qualification of submissions ordinarily requires 3-4 months*. **Step 4**: ***Proposal Scoring***: proposals must be evaluated and scored by review panel(s) organized by the initiating committee. *At least 1 month should be allowed for the review process*. **Step 5:** ***Purchase Order (PO)/Contract***: once a PO or contract is awarded, the consultant can begin work and start invoicing for services. *At least 3 months should be allowed for process*. **Step 6:** ***Expenditure of Funds***: committee monitors the consultant's work and expenditure of funds; for contracts, a "monitoring tool" must be developed and used to oversee the project.	
	Mr. Ma added that there were other factors to keep in mind throughout the process. Stakeholders must be kept informed and their opinions on the project sought out. The committee must also partner with the Executive and JPP Committees to ensure that all pertinent parties are educated about the need for the project. The committee must also coordinate with the Commission Co-Chairs and the Executive Committee to address issues such as timing of the request and framing the message. It is also important to "expect the unexpected". In so large and multi-leveled an infrastructure as the County, he cautioned that vigilance, advocacy and oversight of a project's progress is key to its momentum.	
	Finance work plans were provided for review in the packet. Mr. Ma noted that, at any given time, three budget years were in various stages of monitoring or development. For example, currently Year 12 is being reviewed, the Year 13 budget is being revised and the Year 14 budget is	

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	being developed by the Finance Committee. He added that the Finance Committee is always available to assist Commissioners.	
	Ms. Broadus asked if training or new Commissioners would be part of overall Commission orientation or a separate Finance activity. Mr. Ma said that there would be a Finance training provided every December.	
	Ms. Broadus then asked if Finance would be negotiating the new staffing pattern. Mr. Ma said that, while Finance would have a role, the Executive Committee would take the lead, as far as he knew. Mr. Ballesteros said that he felt the Co-Chairs, with Executive Committee, support would be monitoring that process. Ms. Broadus asked if that would be part of the Executive Committee's work plan to ensure that it was followed. Mr. Ballesteros felt it would become a standing item on the Executive Committee agenda. Mr. Jacobs felt that all Commissioners should be advocating for the staffing pattern with, for example, their Health Deputies, on an ongoing basis.	
	Mr. Jacobs also commented that, as a relatively new member on the Finance Committee, he felt it was one of the best committees with which he had ever been involved. He noted that, with a heavy workload, they could use additional members and he invited members to join.	
V. Public Comment	Richard Hamilton announced the 3rd Annual National Black HIV/AIDS Awareness Day, an event he chaired the prior year. The Board of Supervisors, spearheaded by Supervisor Burke, planned to expand on last year's effort and declare a National Black HIV/AIDS Awareness Week from February 1st to 7th in the City and County of Los Angeles. Special events are scheduled for each day of the week. The kick-off would be February 1st from 10:00 am to 12 noon with a Town Hall meeting at Cooley's Restaurant in Inglewood. A HIV Museum and photo exhibit, plus a screening of "Kevin's Room" with a discussion group, would follow from 6:00 pm to 10:00 pm that evening at the Unity Fellowship Church Social Justice Center. On Sunday, February 2nd, the faith-based community, in conjunction with the Urban Task Force, would give HIV messages at their churches. Beginning January 20th, Martin Luther King's birthday, and continuing throughout February, there would be a drive for testing in the African-American community. Mr. Hamilton added that all were welcome to march with them in the Martin Luther King Day parade to help bring awareness to the community.	
	John Griggs, of the Antelope Valley CAB, introduced himself. He thanked Brad Land, Alexander Gonzales and Genevieve Clavreul for traveling out to the Antelope Valley to assist them in developing their CAB. He announced that he was also submitting his application for the	

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	Commission, so had come to meet people and learn.	
	Rob Thrash, Director, AMASSI's Young Men's Wellness Project, read a letter that had been prepared for the meeting. He explained that until the day before yesterday, AMASSI had expected to give a presentation on outcomes and findings of their Critical Thinking and Cultural Affirmation (CTCA) study conducted in Los Angeles County. The study, he said, provided insight into causes of risk-taking behavior by black males, 18-40, who are aware of HIV/AIDS transmission routes.	
	Mr. Thrash said they had been informed by Al Ballesteros in November 2002 that they had been approved to present their findings to the Commission at this meeting. However, through their own follow-up, they had discovered two days prior that they would not be on the agenda. They were alarmed by this turn of events, both because they found their treatment disrespectful and because of the importance of the information they wished to present on a heavily impacted community.	
	The CTCA study was of black males who self-identified as heterosexual, gay, bisexual, "not interested in labels" and "sexual super freaks". All had male-to-male desire or experience. All reported inability to practice safer sex, protect themselves or prevent the spread of HIV. The findings were informative, he said, and provided key factors for a prevention model that proved effective for 80% of CTCA participants. He felt these findings provided a crucial element of bringing some level of effective primary and secondary prevention to the African-American community and throughout Los Angeles County.	
	Two days prior, Mr. Thrash continued, they were informed that a different process was now necessary for approval of the presentation. Mr. Thrash said they are scheduled to meet with a committee on January 21st to present the study. Since the Commission plays a pivotal role in determining direction and policy regarding how HIV is addressed, they look forward to the opportunity to partner with the Commission to address the epidemic.	
	Paul Scott asked why the presentation was not permitted on the meeting agenda. He noted that there was disparity in the African-American community, so every opportunity for assistance or partnership should be welcome. Mr. Ballesteros replied that a representative from AMASSI had come to the Executive Committee several months ago and referenced a study that they had conducted. While they did not bring the actual study, he said, he thought it sounded as though it would be good to hear. He intended to send it to the Prevention Planning Committee and anticipated that the PPC could present it to the Commission under	

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	their report. That way AMASSI could have committee assistance in presenting the data to the Commission in a comprehensive manner. He said he asked the PPC to work with AMASSI to bring the report to the Commission. Between that request and about a week and a half ago, he said, he learned from the PPC that they did not intend to present the study, for several reasons especially some concerning its design. The PPC felt additional work was needed before it was ready for effective presentation. He continued that he found out after tthat the Commission traditionally asked agencies to report under Public Comment. Under the circumstances, he continued, it was decided that it be sent to Priorities and Planning. The P&P Committee would the decide how to proceed with it.	
	Mr. Molina commented that he had been at the Executive Committee meeting where it had been discussed. He said no information was presented on how the study was done, nor was the study presented. He added that there was also a matter of precedent allowing agency presentations at Commission meetings. He concurred with Mr. Scott that disparity in the African-American community was a serious problem, but he felt that AMASSI was not treated unprofessionally. He felt it was important to be able to read the study and decide how to address it. Dr. Jordan said he thought the process the Commission followed was to send studies to the appropriate committees.	
	Ms. Broadus said she recalled from the Executive Committee that there was an effort to ensure that new information was brought to the table. At the same time, she noted, there was a concern to follow process in order not to open the floodgate for organizations to make presentations at Commission meetings. She recalled that, as the AMASSI study was about prevention, it was referred to the PPC with the goal of them placing it on the agenda. She asked, now that it had been referred to P&P, would P&P assist AMASSI in developing a presentation or would the information be used internally in addressing the linkage of prevention, care and treatment with the report still coming through Public Comment. Mr. Ballesteros said, and members confirmed, that P&P had not yet had the chance to review the study. Mr. Ballesteros said he could not, then, say what decision they would make about it.	
	Mr. Jacobs agreed that a process was necessary and that it was not reasonable to bring something to the full Commission when the Executive Committee had not yet seen it. He found it disconcerting, though, that AMASSI was informed so late that they would not be presenting at the Commission. He felt that should be addressed. Also, considering	

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	the emergency in communities of color, he hoped the report would be fast-tracked so that it could be reviewed as soon as possible. Mr. Ballesteros noted that he became aware of the problem at the Executive Committee the prior Monday. While he agreed AMASSI should ideally have been notified right away, procedural issues caused an unintended delay. He felt the key was to learn from the situation.	
	Ms. Kaplan said she agreed with all of the speakers, underscoring that the material needed to be reviewed. She also encouraged AMASSI to present the key points in Public Comment. She said that she had found Public Comment provided her with much of her best information from the meetings. Since they had come with three people, she noted, they could have done a 9-minute presentation without any restrictions.	
	Mr. Scott said he appreciated the need to see a report to evaluate it. But he felt the Commission was due criticism because there was a huge disparity in the African-American community and the Commission was supposed to be addressing it. Any opportunity to get information that might help the Commission do a better job in protecting the lives of black men should be prioritized. If the report needed to go back to committee, then he urged the committee to get what it needed quickly so the report could be presented. Overall, he said, it was important to limit roadblocks for organizations so they could do the important work that needed to be done.	
	Marc Haupert, the new Co-Chair of the P&P Committee, invited all Commissioners and audience members to forward all reports to that committee. He said the P&P wanted to establish a compendium of studies done in the community. That would support organized presentations of a variety of perspectives on this and other issues.	
	Mr. Henry concurredd that developing a compendium of community studies would be very valuable. He disagreed that reports be presented during Public Comment. He felt it was important from a planning process perspective that agencies and individuals who have taken the time to do research feel they have an appropriate way to partner with the Commission. They should feel assured that there is a process through which their work can be incorporated into the Commission's work. P&P, he noted, has an annual planning process that includes research studies. He felt it was more empowering for agencies to feel that their work actually was impacting the planning process. Mr. Henry also noted that there was a presentation of the study at the PPC as a result of the referral from the Executive Committee, so that part of the process did follow-through.	

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	Vanessa Talamantes said she was at the AMASSI presentation at the PPC. She had not heard, either from AMASSI or from other PPC members, that AMASSI wanted to present to the Commission. Had she been aware of that, perhaps the report could have been included under the PPC report. Ms. Kaplan asked if that presentation prompted questions which led to the delay. Mr. Ballesteros said it had.	
	Ms. Broadus pointed out that P&P is charged with examining service utilization, populations, gaps and disparities. She felt, as Mr. Haupert had said, that a standard policy should be set up to direct any studies for review by P&P. By working through P&P, information can actually be incorporated into priorities and allocations. A presentation outside that process might be stirring, but would have less real effect. She recommended that P&P develop a standard process to be presented to the Executive Committee.	
	Dr. Jordan added that whether doing a preliminary presentation to the PPC or the P&P, the process should clearly inform a presenter whether the report would be heard at the Commission or needed further refinement. He said that the Commission did owe AMASSI an apology for the miscommunication. Mr. Ballesteros agreed and extended an apology for their inconvenience.	
VI. Recess	The meeting recessed for fifteen minutes.	
	Mr. Vincent-Jones announced some housekeeping issues. He noted that the sign-in sheet now had a column to record the time for anyone who needed to leave the meeting early. He noted that it would be of value when putting together voting tallies. He also asked if people would say their names when they spoke. He noted that, while staff recognized most voices, sometimes it was difficult to tell who was speaking on the tape. Finally, he asked that people be sure their microphone was on when they started to speak, since their comments would not record otherwise.	
	Mr. Ballesteros said the revised sign-in sheet was a good idea, but he thought it would also be helpful to have people sign out at the end of the meeting to determine attendance. Mr. Vincent-Jones noted Mr. Stewart had suggested a roll call. Mr. Ballesteros noted that one Commissioner had signed in, for example at this meeting, but only stayed five minutes and then left. That should count as an absence, he thought. Mr. Vincent-Jones suggested the Executive Committee discuss what procedure staff should follow. As far as absences, Mr. Vincent-Jones noted, they had not been clearly defined. On the other hand, he added, the sign-out procedure would document people leaving early.	

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	Mr. Butler asked if it would be appropriate to do a roll call vote after recess. He said he assumed part of the reason for tracking attendance was to ensure quorum, while it was also important to have a consistent record of who remained during the meeting. Mr. Stewart said once quorum was established, it continued until someone said that it was not met. Regarding votes taken, so long as the prevailing vote was a majority of a quorum, it was alright.	
	To general agreement, Mr. Ballesteros said the subject would be discussed in the Executive Committee.	
VII. OAPP Report	Mr. Henry announced that OAPP had completed the Board letter package for the Year 13 Care contract renewals effective March 1st and April 1st for Title I and Title II respectively. He anticipated that the Health Deputies and the Board of Supervisors would hear them in early February.	
	Two additional provisions have been included in the Medical Outpatient contracts. These are based on recommendations and/or dialogue of the Commission as well as good business practices. The first was to incorporate qualifications for HIV specialist medical providers consistent with the recently adopted and implemented State Office of Managed Care regulations that identify the level of qualification that a person with HIV/ AIDS should expect from their medical provider	
	The second contract modification strengthens language to ensure that providers are meeting the State requirement for HIV case reporting. Mr. Henry said OAPP would similarly be working with counseling and testing providers to ensure HIV reporting mandates are met. He noted that, as was discussed at the last meeting, accurate HIV reporting is accurate since State and Federal funding formulas will ultimately transition to use of HIV prevalence rates. Based on experience from other jurisdictions, as well as early reports from Los Angeles County, additional AIDS cases are also identified through HIV reporting. He added that Gordon Bunch would speak more to that issue in his presentation later on the agenda.	
	Mr. Henry also reported that a Federal budget had yet been passed. He said that it was likely to impact when the grant notification for Ryan White CARE Act Title I funds would be received. The grant is scheduled to begin March 1st. Last year and this year, he said, there have been significant delays in the Federal budget process that had a potentially disruptive effect on OAPP's ability to project the level of resources available for planning purposes. Only a 25% allocation is scheduled to be received for the Centers for Disease Control (CDC) award until the budget is passed. That grant year started January1st. Mr. Henry noted	

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	that funding was currently under a continuing budget resolution that extended through January 11th. Congress would either need to finalize a budget at that time, which was highly unlikely, or pass another continuing resolution. Such a resolution would still not reach to March 1st, Mr. Henry noted, so the Title I grant year would still not have any funding stream with a second resolution. He said he would continue to provide updates to the Commission as information became available.	
	Mr. Henry said he wished to recognize the enormous effort of application development. He said he had reviewed the last six Title I applications recently and was struck by the improved planning, program implementation and writing over time. He was pleased and proud of that effort and felt that Health Resources and Services Administration (HRSA) recognized it as well in both feedback and grant awards.	
	He specifically thanked Craig Vincent-Jones, HRSA Grants Manager, and his staff who spearhead the effort to pull together the application as well as contributing a significant amount of the writing. He also commended the Care Services Division under the direction of Dr. Robert Fish, whose work is incorporated into the application. He commended Patricia Gibson, Finance Director, and her staff, who develop the budgets. Gunther Freehill, Mr. Henry continued, had provided key assistance for many years in the finalization of the application's writing and editing. Mr. Henry noted that the entire management team helped support this major annual activity. He said that the application pulls together information from the two key stakeholders: first, the Commission, especially the P&P Committee, develops the process for prioritization and allocation. Second, he continued, care providers, not only provide services but also critically needed data.	
	While formal feedback on the application had not yet been received, Mr. Henry said, there had been feedback from the project officer. Also, both the application and its progress report were in the packet, he noted. Mr. Henry then introduced Craig Vincent-Jones, HRSA Grants Manager, to present a progress report on the Title I application.	
• FY 2003 CARE Act Title I Application	Mr. Vincent-Jones said he would try to highlight areas of change and increased HRSA focus in the application. He noted that both Mr. Henry and Mr. Freehill had already provided excellent presentations on various aspects of the application during the year.	
	He reported that this year's application was 263 pages, noting that is was too small a space to adequately represent the work in the EMA. The supplemental funding section, for example, only allowed 65 pages—the same amount of space that the smallest EMAs had to explain their	

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	work. It is a significant challenge, he remarked, to represent what LA, as the second largest EMA, in so limited space. He said the first draft of the supplemental section was 125 pages, and gave credit to Mr. Freehill for editing that information down into key points. Mr. Vincent-Jones noted that the inequity in the application for larger EMAs had been brought to HRSA's attention.	
	Each year HRSA chooses a few broad themes that recur throughout the guidance, Mr. Vincent-Jones said. Generally, they are not surprising ones, though they change somewhat from one year to the next. The strong emphasis on the Comprehensive Care Plan this year was anticipated. HRSA also wanted to see, he added, that the Comprehensive Care Plan linked the needs assessment, the priority- and allocation-setting process, the implementation plan and all the goals and current progress of the EMA. He pointed out to the Commission how pivotal the work on the development of the Comprehensive Care Plan had been.	
	Another point HRSA has highlighted, he went on, was severe and unmet need. They gave more weight to it last year and continued to do so this year. This year's application required a formula to define unmet need, he said. Consumer membership on the Planning Council was another key issue, he noted. Finally, he said, Quality Management remained an important theme.	
	The total request was $50,461,669 that represented only a portion of the total cost of the program. Mr. Vincent-Jones commented that it was difficult to determine the figure to request. A formula or rational basis is used to attempt to determine a viable figure. Several approaches were examined this year, he continued. One was to use the ratio of new clients. Another was to begin with EMA expenditures on Medical Outpatient services, then take a proportion of that figure. Another was to use the proportion approach with Primary Health Care Core services. All those approaches resulted in figures of $55 to $60 million. That underscored the fact that what is received from HRSA, and even what has been requested, is significantly below the needs of the EMA. At the same time, he noted, it was necessary to be realistic. Last year the request was for $46 million, and $38 million was received. If the request this year had been for $55 million, he pointed out, that would have represented more than a 25% increase and could have been offensive to reviewers. Instead, the formula from last year was reused. That formula utilizes AIDS prevalence, counseling and testing rates, and HIV prevalence. The result was a somewhat lower, but more functional, figure. Even so, the figure represented a 12% increase from last year's	

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	requested amount, and the process of its development was informative.	
	The application has four major sections, Mr. Vincent-Jones explained: 1) Federal Forms, 2) Formula Funding, 3) Supplemental Funding, and 4) Attachments. He then detailed each area.	
	Federal Forms include the title page and maps by SPA for primary medical care sites, support service sites, points of entry sites and CARE Act Title I-funded sites. Points of entry sites is also a theme HRSA regularly addressed, he said. They include counseling and testing; EIP; EIS; all Title programs like II, III, IV and Part F; and federally-qualified comprehensive health centers. In other words, he said, anywhere someone might enter the system.	
	There are five budgets, he continued, beginning with the Administrative Agency budget. The request was for $2,523,083 or 5% of the total request. That is the HRSA limit and the most common EMA request level. The Quality Management Budget was for $1,008,542 or 2% of the total request. He felt most people clearly understood that Quality Management was a programmatic function necessary to ensure and improve service quality. HRSA mandates a level of 5% or $3,000,000, whichever was less.	
	The Planning Council Support budget of $1,764, 949 or 3.5% of the total request represented an increase. That budget was set by the Commission and was within the 5% limit set by HRSA. Implementation of some of the staffing pattern is reflected in the budget, phasing in some positions over the course of the year. Whether that degree of progress is realistic will be reviewed when budget negotiations begin after the award is granted. The budget also reflected funding for some consultants. As was discussed earlier, some consultants would be needed until full staffing pattern implementation.	
	Mr. Vincent-Jones recalled that there was a long presentation to the Commission in September on Program Support. Based on Commission decisions, the request was for $2,521,356 or 5% of the total request. While there is no HRSA limit, a 5% cap is suggested. He noted that both in HRSA's eyes and in EMA usage, this budget was for programmatic support, not administrative purposes.	
	The actual Services request was for $42,643,739 or 84.5% of the total request. It is the largest request ever made by the Los Angeles EMA. It also represents the priorities and allocations as set by the Commission through its process.	
	Formula Funding primarily deals with epidemiology issues, Planning Council membership and Planning Council operational issues. While the	

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	section is not scored by HRSA, it represents about half of the award. HRSA has a formula to derive a figure from this section. The remainder of the award is based on points earned from the supplementary section. Even program officers do not know how the formula used for this section is calculated. They score the proposal, then send it to HRSA Grants Management where the Formula Funding portion is decided.	
	The first part of Formula Funding is HIV Epidemiology to describe HIV prevalence. This year a new estimate of 52,500 was developed of PWHIV/A through the work of HIV Epidemiology. The estimate increased by about 10,000 more people than last year, due to a re-evaluation of those who have HIV/AIDS but do not know it. Los Angeles uses a formula based on known ratios of AIDS to HIV in three western states with populations more similar to the Los Angeles EMA. The three states are Arizona, Colorado and Texas. He commented that there was good feedback last year with the way the EMA handled the formula.	
	The second area of this section, he went on, is unmet need defined as those not accessing medical care. The formula excludes insured and current clients since it can be assumed that those people are already accessing primary health care in some form. Those who are not accessing such care constitute people with "unmet need". That formula will still pose a problem next year, Mr. Vincent-Jones continued, since data on insurance is not very consistent or reliable. Insurance data is an area that P&P might address next year in an attempt to better hone needs assessment.	
	Four tables are part of the Formula Funding section. Table 1 covers AIDS incidence, AIDS prevalence and HIV prevalence. AIDS incidence and prevalence are based on reporting. HIV prevalence is currently an estimate, but would become reporting-based as the new system begins to deliver usable data. Table 2 details Commission membership. Currently, he noted there are 44 of 49 seats filled, with 46% PLWH/A and 33% non-conflicted consumers. He recalled to the Commission the notable effort that had been made to meet the 33% requirement. Table 3 shows the 15 membership categories mandated by legislation. Table 4 shows membership demographics. The new Table 4 in this meeting's Commission packet shows that 39 seats are currently filled, reflecting some member loss, but the non-affiliated consumer percentage has increased to 39%.	
	Planning Council Membership is also addressed in the narrative. Currently, he commented, the Commission is low on Latino/a, HIV+ Asian and HIV+ transgender membership. The Commission was compliant	

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	with consumer membership requirements and the process for meeting them as of September 2002. For this section, vacancies must be described along with efforts to fill them. He added that HRSA follows vacancies closely. HRSA requires an ongoing, comprehensive training program for Planning Councils. The application described the increase in presentations, as well as RD&B's efforts to develop that program.	
	Partner Assurances are the last section of Formula Funding. Mr. Vincent-Jones noted that HRSA did not renew last year's requirement to assure completion of the Assessment of the Administrative Mechanism. The other Planning Council assurances remained in force. CEO Assurances are for maintenance of effort and delegation of authority to the grantee. Mr. Vincent-Jones pointed out that the $15.9 million in maintenance of effort funds is not matching funding. Rather, funds are committed by the County and the commitment must be maintained regardless of the amount of grant funding.	
	Supplemental Funding is the scored section. The total section is worth 100 points and represents about half of the final award.	
	Grantee Administration is worth 31 points. Conditions of Award (COA) account for 26 of the 31. The application earned 25 COA points, losing one due to failure to meet the initial consumer membership requirement deadline in April.	
	The Grantee Administration subsection requires description of how the grant is administered through program and fiscal monitoring. For example, he said, 100% of providers received administrative audits this year. Also, 91% of providers and 84% of contracts were monitored, important since HRSA wants to see program monitoring at least every two years. Increasing the percentage of fiscal audits remained a challenge since they are not performed by OAPP. The County Centralized Contract Monitoring Division (CCMD) performs all fiscal audits. HRSA requires a description of Eligibility Screening. That was addressed, Mr. Vincent-Jones continued, with the improved screening practices. HRSA also requires a description of the follow-up on last year's Administrative Assessment. Mr. Vincent-Jones stated that there were nine principle recommendations last year. Significant progress was made in seven of those.	
	Severe Need is worth 33 points or one-third of the score. It is divided into three sections of 11 points each: HIV/AIDS Epidemiology, Co-Morbidities and Special Needs Populations. He underscored that this area of the application is competitive among EMAs, that is, funding will be allocated according to the greatest proven need. Factors that are	

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	considered include co-morbidities like STDs and TB, homelessness, mental illness and substance abuse, new and emerging populations, and relative costs of providing care.	
	The *HIV/AIDS Epidemiology* section (11 points) follows the Comprehensive Care Plan theme of emphasizing the tension resulting from multiple, concurrent epidemics. Different services have to be offered and need to be offered in different forms. With each adaptation of a service to meet the needs of a special population, he noted, the cost and complexity of the service rises. The narrative of the application addresses comparative descriptions of populations, disproportionate impact among special populations and against the overall epidemic, and the level of estimated unmet need based on demographics versus service utilization.	
	Co-Morbidities represent another 11 points. Table 5 begins the subsection with Quantitative Data on co-morbid conditions. Those are TB, STDs, Hepatitis C, substance use and homelessness. Other data included is on poverty and insurance. Table 5 data is developed in the narrative with summaries of the information and sources for it. The Impact on Cost and Complexity is developed in the narrative. There are seven complexity of care indicators. He pointed out that 10% of clients have three or more complexity of care indicators and 5% have five or more. A focus for next year will be to collect more outcome indicator data to strengthen the formula used in this section.	
	Regarding Increased Access to Care, Mr. Vincent-Jones continued, clients have increased by about 4,000, or about 25% of the client population, during the past year. That is an exceptionally large figure that was stressed in several places. Six service categories were reviewed. Both clients and severity of conditions increased in all categories. Dr. Jordan asked if the 4,000 figure represented new patients or transfers from private. Mr. Vincent-Jones said there was not good data on that specific question, but most clients had not been in the system previously. Gunther Freehill noted that even those who might have had care through private insurance before were still new to CARE services.	
	Reduction in Morbidity/Mortality must also be demonstrated, Mr. Vincent-Jones continued. The Comprehensive Care Plan clearly demonstrated that access to care reduces mortality. An analysis of system level outcomes shows that the earlier the access to care, the longer clients stay healthier. System level outcomes, like CD4 results, were analyzed to demonstrate that clients are being served effectively. It is planned to develop additional system level outcomes data for next year	

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	to further enhance this section. For example, OAPP will work with providers to enhance data on syphilis serology.	
	Special Needs Populations (11 points) is the final subsection of Severe Need. Table 6s are completed for both mandated and optional special needs populations. Mr. Vincent-Jones said the data developed for the Comprehensive Care Plan was of great assistance in preparing this sub-section. Due to that work, the application was able to rely more heavily on the Table 6s than in previous years. Mr. Vincent-Jones noted that Jo Messore, Project Officer, had said that LA's Table 6s were superior to those of most other EMAs in the past, but this year's were exceptional. Also, due to data collected for the Comprehensive Care Plan and some additional data collection, it was possible to realize a goal of several years to add three new special populations. The three are: severely mentally ill, transgendered, and the undocumented. While much of the data collected was qualitative, it had been collected through the Needs Assessment process. That process assured that it was collected reliably, consistently and methodically. It was asked what "optional" indicated for a table. Mr. Vincent-Jones replied that the first six categories are mandated for all EMAs by HRSA. Each EMA may choose whether or not to add additional special populations depending on local needs.	
	Mr. Vincent-Jones commended HIV Epidemiology for their continuous assistance in developing this data. For example, he noted, even such questions as defining "women of child-bearing age" have an impact on data. That question was debated for several days. Each time a population definition is adjusted, the data must be rerun to match it. Douglas Frye reconfigured data many times to meet improved definitions. He also collected and refined data for the Comprehensive Care Plan that had never been gathered before. That work significantly strengthened the Table 6s.	
	Impact of Title I Funding (6 points) is the next section of Supplemental Funding. This year only a description of changes from last year was required. Changes highlighted from last year were: a non-hierarchical and non-linear approach to service systems; multiple entry points; consideration of multiple morbidities; improved integration, collaboration and outreach; better relationship between patient care coordination and care services; and strategies to reduce structural, organizational and individual barriers. Some of the areas addressed were: primary health care network, counseling and testing, targeting BRGs, collaboration with substance abuse services, more care services, standards for pregnant women, work in the jails, and increased transportation funding.	

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	Changes in Access to Care also needed to be described. Some items described were: Prevention for HIV-Infected Persons (PHIP), patient care coordination, service delivery and coordination, standardization and definition of service protocols, Minority AIDS Initiative (MAI), and the Hepatitis Demonstration Project. Much of OAPPs work on standardization and definition of service protocols was addressed in this section. The Commission's work on standards was also used.	
	Coordination of Services and Funding Streams is another required area of discussion, he went on. Some data, like that for ADAP and other Titles, is easy to access. Medicaid and Veterans Affairs data has been difficult to capture. An explanation of funding stream coordination is required, showing that the EMA coordinates well with the funding streams for which HRSA requests information. The Financial Needs Assessment will enhance that work in the coming year.	
	A description of the *Use of Telehealth Modalities* is also required. This section is based on a new initiative at the HRSA level. There has been no guidance released or any information on how EMAs should address it. They asked for a description of what the EMA was doing and what was being considered. Mr. Vincent-Jones felt it was likely that HRSA was assessing the state of the subject around the country. Areas described in the narrative were: HIRS, on-site electronic evaluation mechanisms, websites, on-line AIDS Resource Directory, and SPINS.	
	Table 8: Title I in the Context of Other Funding acoompanies this section. The estimate provided for this application was $306,202,334 for HIV/AIDS services are available in Los Angeles County. While it is believed that is a very low number compared to services in the community, he noted, it will be necessary to complete the Financial Needs Assessment to develop a more accurate figure. The current figure is based primarily on ADAP, other Title dollars, Los Angeles County funds and Attachment Es. Attachment Es are forms providers are required to submit each spring that describe all their services and the funding streams for them.	
	Planning Council Responsibilities (10 points) is the next subsection required. *Table 7: Priorities and Allocations* details priorities set by the Commission. *Table 9: FY 2002 Priority/Allocations* details allocations according to the priorities.	
	The *Comprehensive Care Plan* is described in this subsection. Description includes the process used to develop it, how the plan is used, community education and information about it, linkages between needs assessment and plans, and eliminating disparities. There is also	

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	discussion of next steps in this area.	
	Compatibility with SCSN, that is, the State Coordinated Statement of Need must addressed next. The State (Title II) is currently in the midst of redeveloping their version of a comprehensive care plan. As they were not finished in time for the application, Mr. Vincent-Jones noted, parts were used from both the new and old plans. He suggested that the Commission request Dana Pierce-Hedge, the State's representative on the Commission, to elaborate on the State's progress.	
	Finally in this subsection, the Commission was asked to address the *Assessment of the Administrative Mechanism.* A final report of this was not required, but a progress report was included.	
	The next subsection was Quality Management (10 points). HRSA had suggested this was an area that could be improved from last year's effort. This is also an active area, he said. Several allocated positions for Quality Management were approved just since submission of the application. *Activities During FY 2002* were described, as was *Use of Costs in Evaluation Services*, exemplified in the application by discussion of the rate review. Excellent work is being done with the *Process in Developing Outcome-Based Service Evaluation*. It was outlined that there are outcome measurements for every service category. Last year HRSA suggested that the EMA request technical assistance in outcome development. That was done and the EMA is now working with two technical assistant contracts in that area.	
	FY 2002 Plan Progress (5 points) is the next subsection. Like the Finance Committee's work discussed earlier in the meeting, Mr. Vincent-Jones noted, three implementation plans need to be addressed all at once. While planning for next year, it is necessary to report on progress with this year's plan, as well as present results from last year's plan. HRSA complemented last year's Table 10 as the best some of them had ever seen. This is the table at the end of the application that outlines goals, objectives and services for the year. There are biannual reports required on their implementation. Last year presented a notable challenge because it was necessary to take the Continuum of Care and convert it to the Table 10 format. This year, the Commission's changes in priorities and allocations had to be incorporated.	
	Table 10: FY 2002 Implementation requests ten Accomplishments to Date. Rather than cite individual items, this application cites categories of items. That allows more leeway in the section, so that nearly 100 items are covered. To date, HRSA has not objected to this approach.	
	A description of On-Going Challenges is also part of the progress plan.	

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	Lack of capacity was described, as were data management challenges. Inadequate staffing described a variety of problems in finding, hiring and retaining OAPP, Commission and provider staff. Challenges discussed in the political environment reflect issues with those attempting to undercut the decision-making process and the authority of pertinent bodies like the Commission or OAPP. Transportation was also listed as a constant service challenge.	
	WICY Services (Women, Infants, Children, Youth) also must be described. It is necessary to document for HRSA that at least as much funding is allocated to those populations as their numbers reflect in the client population. WICY are estimated to represent about 15% of the client population and receive about 20% of funding. To enhance estimates of client population and service provision, this year providers were asked to invoice WICY services separately. That data will be available to enhance estimates for next year's application.	
	FY 2003 Plan (5 points) is the final subsection of the application. *Table 10: FY 2003 Implementation Plan – Services and Goals* provides a blueprint for the next year's work. In the narrative, Access to Care/Reducing Barriers must be addressed here. Subjects discussed here were: providing access to care, special population and geographic allocations, building capacity, partnerships for care, and allocating resources to WICY. Some approaches to reducing barriers discussed were the geographic estimate of need, geographic access, the referral and linkage systems, co-location of primary health care and patient care coordination, and use of the MAI funding.	
	Mr. Vincent-Jones summarized that this application is always a daunting task. At the same time, the application provides an opportunity to truly evaluate and appreciate all that the EMA has accomplished during the year. Beyond that, by compiling the work in a format of this type, it becomes apparent how much all the partners – the Commission, OAPP, the Department of Health Services – are doing to ensure services for people with HIV/AIDS are reaching those who need them. Finally, he again commended the work of the Comprehensive Care Plan and underlined how important it was in developing the application.	
	There were several questions regarding the make-up of the 4,000 new HIV clients noted in the application. Mr. Henry recommended that a separate report be scheduled to address in detail the nearly 17,000 clients in the system. Such a report, he noted, could provide basic demographic data, information on services being accessed and other data, all of which was used in the report. Mr. Ballesteros suggested to	

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	general agreement that the Executive Committee would schedule a report with the assistance of P&P. Mr. Freehill also agreed and added a new client may, or may not, be receiving medical care through the system. S/he could also be a MediCal or private insurance client just now accessing such services as mental health or case management.	
• Special Projects of National Significance (SPNS) – *HIV Interface Technology Systems (HITS)*	Mr. Henry then introduced Mario Pérez, Director, Prevention Services, for an overview on the recently received HRSA funding for the Special Projects of National Significance (SPNS) grant for the HIV/AIDS Interface Technology Systems (HITS) project. Mr. Henry said the directors of the Care Services, Prevention Services and Information Systems Divisions are jointly heading this important project.	
	Mr. Pérez noted that this $1.6 million grant award over four years was one of only six nationally, as well as the only health department, and the sole jurisdiction west of Louisiana. He added there were about ten counseling and testing slides in the presentation that not in the packets. They were available on the website and were being provided for context.	
	This new initiative was in response to HRSA'a interest in using Information Technology (IT) to improve the care delivery system. The proposal was designed to enhance the HIRS system and address several areas that would benefit by improvement. One such area was how well people were supported in returning for their counseling and testing results. Another key area targeted for improvement was the time lag between a client receiving a positive test result and accessing the care system. The third targeted area was to improve client screening for service eligibility to maximize HRSA funds of last resort. The goal of the SPNS initiative is to evaluate the impact of IT and its improvement on delivery of quality of care for individuals living with HIV, as well as to optimize use of funds. All award grantees are using IT to improve their data collection or client delivery.	
	HITS was designed to optimize delivery of health care through the counseling and testing follow-up piece. In addition, it was designed to optimize outcomes through a strong Quality Improvement (QI) component. The premise was that by helping people to become aware of their status more quickly, new infections in Los Angeles County could be reduced. That, in turn would reduce health care costs, especially those for late stage treatment, making the program cost-effective.	
	Much of the annual $400,000 grant was expected to be invested in a few key areas, Mr. Pérez continued. First, three key staff are projected: a project manager (PHN), a project evaluator (Ph.D.) and a project coordinator. The Public Health Nurse will be responsible for reviewing	

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	current counseling/testing and care service delivery systems to ensure there are healthy bridge mechanisms between them consistent with the Continuum of Care. The project evaluator will be a doctoral level researcher to prepare IRB packages and focus on the evaluation plan that is a significant part of the initiative. The project coordinator will manage day-to-day efforts of the initiative, as well as provide a focus on the CARE Act service eligibility system and the HIV/LA Resource Directory to ensure the current internal systems are optimized.	
	There are three problem areas that HITS was designed to address. Close to 25% of clients tested do not return for their results. Of the 80,000 tests conducted through OAPP, that equals some 20,000 tests a year. On average, about 228 of these would be positive, presenting a continuing infection risk. Many clients also learn that they are positive, but do not access care. Again, that statistically raises the risk of infection, as well as compromising the opportunity to treat the virus most effectively for the best possible health outcomes. Finally, many clients are unaware of what resources, CARE Act and/or other, are available to them. That lack of knowledge results in both lack of appropriate care and care rendered via less cost effective funding. This initiative can also have a significant impact on Partner Counseling and Referral Services (PCRS).	
	Mr. Pérez then provided an overview of current Counseling and Testing Services in Los Angeles County. Of the 80,000 publicly funded HIV tests, a high rate of nearly 47% is anonymous. About two-thirds of tests funded occur in community-based settings, through community-based sites, the 26 STD/TB clinics, mobile testing units (19%), the Drug Expansion Program at drug treatment and methadone centers (5%), and at three Courts (2%). Courts have a high positive prevalence, he noted. SPAs 4, 2, 6 and 7 are highest in terms of tests. In regards to positive test prevalence, SPAs are ranked: 4, 6, 7 and 2. That is consistent with distribution of the epidemic, he noted.	
	The disclosure rate varies among the five predominant service delivery sites from 65% to 83%. Positive disclosures vary from 54% to 83%. In 2001, about 228 persons tested positive but did not learn their results. That was about one-fifth of positive tests, which number about 1,200. Dr. Jordan asked if the clients were unduplicated. Mr. Pérez noted, since 47% were anonymous, that could not be accurately evaluated.	
	Expanding on test types, Mr. Pérez explained that it was felt the 53% confidential test rate was too low. Follow-up can be initiated with clients who test confidentially, but follow-up is not possible with the 47% of	

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	anonymous test clients. While anonymous testing is important, it is believed that counselor preference for testing type may play a significant role in the client's choice. Counselor training could mitigate the high number of clients who are currently lost to follow-up. Robert Butler said he had previously worked at an anonymous test site. Those who tested positive were encouraged to return for a confidential test. He asked how that would be captured. Mr. Pérez answered that would be reflected as two distinct tests.	
	Regarding testing by gender, he noted that a strong proportion of women were testing for HIV. The highest proportion of positives remains among men in this EMA. About 950 positive test results, or 84%, are among men. About 156 positive test results were reported among women and 12 among transgenders. There were also about 7% listed as unknown due to a lack of data.	
	Latinos accounted for 42% of positive test results. There were also about 348 positive test results among African-Americans, about 225 among whites, 33 among Asian-Pacific Islanders, and 13 among Native Americans-Alaskan Natives. Most people in Los Angeles County, he continued, test positive between 30 and 39. It is estimated that about 50% of new infections are among people 25 years old or younger, but many delay testing.	
	A significant proportion of positive test results are among the MSM population. However, he pointed out that it was alarming to note that more than one-half of all tests, and one-quarter of positive test results, were among those with no identified Behavioral Risk Group (BRG) factors. Mr. Pérez felt those numbers reflected several issues including reporting, counselor capacity to elicit true risk behavior, and other factors	
	Tom West commented that what was alarming was not that the non-BRG population constituted 55% of the tests, but that so many were not providing accurate information. Mr. Pérez underscored the concern that a counselor who cannot identify a client's true risk factors would not be able to accurately develop a risk reduction plan. Mr. West agreed, but noted that a first-time client might not want to reveal sexual or drug risks regardless of how talented the counselor might be. While a serious concern, he said, the numbers should be viewed in context even as improvement is sought.	
	Mr. Ballesteros commented that enhanced training was important. But, he added, policies around non-BRG testing might need revision if numbers remained high despite enhanced training. Mr. Henry pointed out that data being reviewed was from 2000. In the resolicitation for new	

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	counseling and testing contracts, he said, there was a financial incentive to reach high-risk populations. He continued that a second post-disclosure counseling session was added to those contracts to support the building the relationship to foster disclosure. A newly positive client can see the same counselor for testing, to receive results, and a second follow-up. S/he should immediately begin receiving referrals to programs that appropriately meet the needs, Mr. Henry added. If a person discloses a BRG on the first or second follow-up visit, the client risk status would be changed from unknown to the appropriate BRG. Mr. Jacobs asked if rapid testing would not eliminate many of these problems. Mr. Pérez answered that was an entirely different discussion. Mr. Henry suggested a separate presentation on that.	
	Mr. Pérez continued that return rates also vary by type of site where testing occurred. There is an overall return rate to receive results of about two-thirds for Los Angeles County Public Health STD and TB clinics, with an 82% return for those who are positive. It should be noted that County sites only do confidential tests. The three Court sites mandate a counseling and testing session, thus maintaining the highest rates. There was an overall return rate of 75% for the Mobile Test Units, with a 54% return rate for those who tested positive. Rates can be compared to national goals of an 85% return to receive results, with a 90% return among those who test positive.	
	Mr. Pérez reviewed the HITS goals in light of the counseling and testing data just discussed. The key goals are to ensure all those tested return for results, reduce time between testing positive and entering care, improve local ability to screen for service eligibility across funding streams. Mr. Pérez then described the interfaces of the new HITS project. The project targets those who test confidentially, but do not return for results. No follow-up is possible for those who test anonymously.	
	The first interface, Mr. Pérez continued, is the HIV Status Follow-up System (HSFUS). An electronic tracking system, HSFUS will alert counseling/testing staff of the number and contact information for positive or high-risk clients who tested confidentially but did not return for results. Staff will be prompted to follow-up with these clients within a programmed time frame. The electronic prompt will ensure that the pertinent follow-up is initiated within a certain tame.	
	Mr. Jacobs expressed concern that follow-ups might disclose the client's status to other family members. He also noted clients will be encouraged to test confidentially rather than anonymously. He felt that was undue influence. Mr. Pérez said anonymous testing would be	

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	maintained. Mr. Jacobs said he was concerned that encouragement itself would undermine the client's right to choose. In some instances, he noted, disclosure of testing increases the risk for family violence. He felt the method of viewing testing was being changed.	
	Mr. Henry answered that a longer discussion might be held on the subject, though this protocol was consistent with Prevention Planning Select Committee direction. He added that County clinics were already taking this approach without dire consequences. In addition, the stringent State requirements for confidentiality remained in effect. Mr. Henry called attention to data indicating the influence of counselor, rather than client, preference. With treatment options improved, patients deserved a full opportunity to be educated about their options, he said.	
	Ms. Talamantes suggested language might be the problem. She proposed instead of telling counselors should encourage clients to test confidentially, the direction might be for counselors not to encourage clients to test anonymously. Mr. Pérez suggested saying that they wanted counselors to comprehensively describe the benefits of both testing options. There was consensus that that was better.	
	Mr. Ballesteros noted there was 50 minutes left for the meeting and four important motions. He said it was important no one leave or quorum would be lost. He asked that comments be kept to a minimum to ensure the other work of the Commission was accomplished.	
	Mr. Pérez said the next interface, HIV Referral Follow-up System (HRFUS), was designed to ensure clients are assisted with access to appropriate care. Basic client information will be used to provide accessible medical and social services referrals by linking with the on-line HIV/LA Resources Directory. Unique client identifiers will be used to notify care providers of referrals and providers, in turn, can provide confirmation to the referring agency that the client has entered care. Where entry into care has not been documented, client follow-up will be initiated.	
	The final interface is the CARE Act Services Eligibility System (CASES). This electronically enhances the IMACS/Casewatch client eligibility screening module. Care providers will have enhanced ability to screen clients for CARE Act or other service eligibility.	
	Overall, Mr. Pérez anticipated that more individuals would test confidentially due to better patient education, that more HIV+ persons would learn their status, and that more would enter the care system with less delay. He noted that data showed those who know they are positive reduce risk-taking behavior, which would reduce new infections and	

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	associated costs. A better understanding was also anticipated of demographic and behavioral factors that impede access to care.	
	Mr. Pérez called attention to three anticipated quality of care and clinical outcomes. The improved access to care would support early intervention and initiation of primary healthcare for newly diagnosed clients. Quality of care would be enhanced by cross-referral of clients from counseling/testing to both primary and support services. Disease progression would be delayed due to expedited access to care.	
	Mr. Pérez noted many funding partners also have a significant focus on cost-effectiveness outcomes. Due to higher numbers of people learning their status, he said, HIV prevention would be improved, thereby mitigating costs. Medical care costs associated with mid- and late-stage disease would be reduced through early treatment. Improved counseling/testing return rates would maximize testing investments. And, he noted, other sources of care services funding would be maximized through better assessment of needs and eligibility.	
	The first of the four annual grant awards was received in September, Mr. Pérez noted. The project definition should be completed by the end of January. By the end of March 2003, the evaluation plan should be complete and all staff hired to prepare for the project's launch at the beginning of July 2003. Currently, an IRB exemption application was being completed and a logic model was being developed for HRSA. There are also hypothetical questions being developed that it is hoped will be answered at the end of the project. They will be shared with the Commission once fully framed.	
	Mr. Pérez summarized his report by noting that this could be seen to entail a paradigm shift in how services are provided. In many ways, however, Los Angeles County has been at the forefront of many such shifts. For example, Los Angeles County adopted the Behavioral Risk Group (BRG) model far ahead of the national curve. Today, counseling/testing services must have a BRG focus. Also, Evaluation and Quality Improvement plans are required of all providers. Mr. Pérez felt this project was consistent with the EMA's national leadership on a number of levels.	
	Dr. Jordan complimented Mr. Pérez on his presentation. At the same time, he felt it was important to ensure it was discussed more fully by the Commission. Brad Land concurred. It was agreed that the Executive Committee would return the subject to the Commission.	
	Mr. Ballesteros asked if quorum still existed. The Parliamentarian, Mr. Stewart replied that quorum existed until it was challenged.	

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	Mr. Ballesteros noted that there were motions that needed to be addressed along with a few other items. He asked for a meeting extension of 15 minutes. Agreement was general.	**MOTION #2**: Extend the meeting for 15 minutes ***(Passed by consensus)***.
	Mr. Ballesteros said the meeting would then move to the motions, starting with the Finance Committee.	
	Andrew Ma, Finance Co-Chair, presented their motion to extend the contract (originally a purchase order) for the Assessment of the Administrative Mechanism for a year in order to conduct the FY 2004 (YR 14) Assessment of the Administrative Mechanism. The contract is with Non-Profit Management Solutions. The motion includes authorization for the Executive Committee in consultation with the Finance Committee to determine the strategy with which to advocate it to stakeholders. He noted that the YR 14 application would be due in October, so there would only be six months from the time of the YR 13 presentation to do the YR 14 Assessment.	**MOTION #3**: Approve renewal of Non-Profit Management Solutions contract ***(Passed unanimously)***.
	Mr. Stewart noted that as the motions are written in the agenda, which has been approved, they do not have to be moved or seconded. They only need to be debated and voted.	
	Mr. Ballesteros continued to Motions #4 and #5, brought by P&P. Brad Land, Priorities and Planning Co-Chair, noted that a great deal had been heard at the meeting about the importance of the Comprehensive Care Plan. The Committee's motion was to approve a Solicitation of Bids for the design and publication of the Comprehensive Care Plan, following its revision in March 2003. Mr. Freehill asked if funds were already budgeted. Mr. Land replied that the purpose of the bids would be to ascertain how much would be needed. At this point, the Committee had no basis for an estimate.	**MOTION #4** Approve Solicitation of Bids for design and publication of the Comprehensive Care Plan ***(Passed unanimously)***.
	Mr. Land said that P&P would like to renew and extend the contract with Partnership for Community Health (PCH) for two years at a cost of $300,000. The purpose, he continued, would be for Comprehensive Care Plan revisions, needs assessment, priority- and allocation-setting, and consumer expressed need data collection and analysis work. P&P also requested, he said, that the Executive Committee, in conjunction with P&P, would determine the strategy with which to advocate it to stakeholders. P&P has issued two RFPs with national distribution, Mr. Land noted. PCH was chosen both times. P&P felt it had given adequate attention to selecting professional expertise for planning support. Combined with the Committee's excellent experience with PCH over the past year, the Committee felt PCH would continue to produce high-level results. He noted that Jo Messore, Project Officer, wrote that she	**MOTION #5:** Approve renewal and extension of contract with Partnership for Community Health for Comprehensive Care Plan revisions and associated planning support work ***(Passed unanimously)***.

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	wished to " congratulate you . . . at the CHHS for developing an excellent Comprehensive Care Plan to provide services for People Living With HIV/AIDS in the Los Angeles Eligible Metropolitan Area." Mr. Land felt that acknowledged the work that was supported by PCH. There was no additional discussion on the topic.	
	Mr. Gonzales, RD&B Co-Chair, brought the next motion--stating that the Committee was asking to restart the Public Awareness Campaign. As the Commission was aware, it had been put on hold on hold after only about two weeks and 4 ads. Mr. Gonzales noted that an overview of the campaign was in the packet. Key purposes were Commission membership, consumer/community education about the Comprehensive Care Plan and Commission planning activities, consumer involvement in creation of the consumer advisory council mechanism, community education on the critical nature of the Commission's work, and reduction of disparity in involvement. Key stakeholders, he added, were the Executive Committee, the Commission, the Department of Health Services, the Board of Supervisors (Health Deputies), and the larger community. He added that a survey letter had been prepared by the RD&B in order to better reflect the needs of stakeholders in the renewed campaign.	
	While the budget has not been fully reviewed, he noted, the motion is simply to restart the campaign. Tom West asked if they were being asked to approve a campaign without a budget. Mr. Gonzales replied that the budget had already been approved previously. Because the campaign was stopped so quickly, few funds were spent. The budget included in the package provides a draft proposal for review by the Fiscal and Executive Committees to rework funding already approved.	
	Mr. Perry asked what would be done differently this year. He felt last year's campaign was very ineffective. There was no follow-up or evaluation of how many people were reached or applied to be Commissioners, he said. He felt a great deal of money was spent to little effect. Mr. Ballesteros noted it was stopped within two weeks, so the campaign barely got off the ground. Even at that, Mr. Gonzales noted, some 35 inquiry calls were received. Mr. Freehill added that very little money was spent. Mr. Gonzales added that some things were being done differently as well. For example, the Board of Supervisors was now very well aware of the Commission activities. The Health Deputies are also very much behind the campaign. In addition, he said, the assessment survey was not done last year.	
	Mr. Jacobs asked about the Health Deputies' interest. Mr. Gonzales replied that they were now well informed and had suggestions regarding	**MOTION #6**: Restart the Commission's public awareness

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	aspects of the campaign. Last year this was not the interactive partnership with them that exists now. Mr. Land contributed that the consumer education focus was enhanced in this campaign. Mr. Gonzales encouraged Commissioners who were interested to participate in development of the campaign with the Committee.	campaign, with a budget determined by the RD&B and Executive Committees ***(Passed: 18 ayes, 0 opposed,, 2 abstentions).***
	Mr. Ballesteros then brought forward the summary reports. He asked if there was any discussion. As there was none, each summary the approved without correction.	**MOTION #7**: Approve Summary Report of August 28, 2002 ***(Passes unanimously)***.
		MOTION #8: Approve Summary Report of September 12, 2002 ***(Passes unanimously)***.
		MOTION #9: Approve Summary Report of December 12, 2002 ***(Passes unanimously)***.
VIII. State Office of AIDS Report	Ms. Pierce-Hedge not being in attendance, there was no report. Mr. Vincent-Jones reported that Ms. Pierce-Hedge had been called for jury service and had been assured that she would be released in time for this meeting, but unfortunately was not.	
IX. HIV Epidemiology Report	Gordon Bunch, Director HIV Epidemiology, said he would be present a brief update on the status of HIV reporting in Los Angeles County. First, he answered the question Dr. Jordan asked Mr. Pérez earlier in the meeting. He had asked, Mr. Bunch recalled, if repeat viral load testing would require repeat case reporting. The answer is no; if a provider maintains the log that is supposed to be kept at the site, the provider should know when a case has been reported.	
	Mr. Bunch said there was still great difficulty in obtaining case reports, but it was getting a bit better. An additional 321 cases were reported since the report of November 30th. The Los Angeles total is now 868, with an additional 409 from Long Beach and 13 from Pasadena. The overall total is 1,290. State report data will be slightly different as they receive Los Angeles County data on the 15th of the month, that is, through December 15th for December. Another 500 reports were received in the past two weeks. Most of those were from Kaiser facilities. They are beginning to report in bulk.	
	Of the 1,290 reported by December 31st, he continued, 84% are male, 16% are female. He noted that he was reporting this information as he had been asked to provide an overview of this information monthly. However, until numbers were larger, the percentages must be considered only preliminarily. Ethnic percentages are: whites, 37%; blacks, 25%; Hispanic, 34%; Asian, 2%; Unknown, 2%. This is similar to case	

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	data.	
	What he did find striking was that 37% of the cases reported were from public sites and 60% from private sites. Reporting from public sites is much lower, he noted, than is typical with AIDS case reporting. That means that the bulk of reporting providers are not Ryan White CARE Act providers. The last four digits of the Social Security number are present in 91% of the cases. That shows that compliance with the needs of the coded identifier is good.	
	He noted he was also asked to report on cases per SPA. The total case reports received since July were: SPA 1, 0; SPA 2, 44 HIV case reports; SPA 3, 33 HIV case reports; SPA 4, 84 HIV case reports; SPA 5, 5 HIV case reports; SPA 6, 12 HIV case reports; SPA 7, 117 HIV case reports; SPA 8, 216 HIV case reports.	
	He also reported that he had met with the P&P Committee after the last meeting. He participated in the discussion of the letter that the Commission plans to approve and send to Ryan White CARE Act providers. It was felt at that meeting, he said, that it would probably be helpful to send the letter to private providers as well. Even though they would not be Ryan White CARE Act provides, he noted, they still need to know and understand the data. He and Nettie DeAugustine will continue to work on that letter and the mailing distribution for it.	
	He will also be reporting in detail to the P&P Committee on a quarterly basis, he said. He and/or his staff will participate in each meeting to better partner with the Commission on the status of HIV reporting, the obstacles being faced and possible solutions to the obstacles.	
	He noted that HIV Epidemiology has received about $600,000 in one-time support for 12 staffing positions to help with the backlog of cases. They are positions for this year only, as he will not have the funds to support them after that. Six positions will be field positions, going out to sites to help in reporting cases. Other positions will data entry to enter case data. A couple will be computer programming positions, especially for those who have familiarity of statistical analysis software like SAS. There are two research analyst positions as well. Anyone who knows a potential employee was asked to refer the person.	
	He closed by noting that this must be a community effort. OAPP could only do so much by changing contract language, he noted. Everyone should encourage their physicians to report.	
	Mr. Henry recommended that the chairs initiate a discussion with the Commission representative from the Los Angeles County Medical Association, Dr. Eugenio. Though she was not in attendance, this is an	

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	issue for them and OAPP has less leverage over the private providers. Identification of strategies to increase their adherence would be helpful. Mr. Ballesteros said he made a note of the recommendation.	
X. Select Committee on Prevention Planning Report	Mr. Mendia said the Prevention Planning Committee convened on Tuesday. By unanimous vote, it was decided to continue the use of the BRG model for the development of the HIV Prevention Plan for 2004-2008. The alternative was to revert to a targeted population model. There has been considerable discussion about the actual implementation of the BRG model at the level of community-based organizations. This is a critical time to provide input to the BRG model. There was also a continuation of Dr. Douglas Frye's epidemiological update from last month. The slides were not available for this packet, but Mr. Mendia said he would include them for the next meeting.	
	As Part of their ongoing colloquia on research, a presentation was given on whether or not the legislative mandate to HMOs to allow patients with HIV to self-refer to an HIV specialist was actually increasing the number of such referrals. The data presented indicated that it does, he said.	
	Ms. Talamantes added that the community co-chairs had asked Mr. Henry's assistance in identifying a consultant to write the 2004-2008 plan. If anyone knows someone who might be a good applicant, she said, refer the person to Mr. Henry's office. Mr. Henry commented that the contact person should be Gabriel Rodriguez.	
	Mr. Talamantes continued to say that the Community Planning Leadership Summit would occur in March. Several people from the PPC and the office had submitted abstracts, she said. No responses had yet been received, but it had been heard that several had been accepted. She suggested that one or two people from the Commission also attend if possible, especially in light of the discussion of integration of HIV care and prevention planning processes.	
	At the last Commission Executive Committee meeting, she added, the recommendation to merge the Commission and PPC was discussed. It was decided to hold a joint meeting of the two executive bodies to develop discussion points for the two bodies.	
	MR. Jacobs commended the PPC for the letter it had written to Governor Davis to preserve prevention dollars (copy in the packet). It appeared though, he commented, that prevention might be taking another hit.	
XII. Standing Committee Reports	Due to the time, Mr. Ballesteros asked if any of the standing committee reports could be deferred.	
• *Finance*	Mr. Ma deferred other Finance Committee information since the motion had already been approved.	

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• *Priorities & Planning*	Mr. Land noted that he and Marc Haupert had been elected Co-Chairs. As their motions had been approved, other material was deferred.	
• *Recruitment, Diversity and Bylaws*	Mr. Gonzales also deferred other material since the motion had been approved.	
• *Standards of Care*	Committee material was deferred.	
• *Joint Public Policy*	Committee material was deferred.	
XIII. Co-Chairs' Report	Mr. Ballesteros agreed to defer most of the report.	
• Retreat Review/Follow-Up	Deferred.	
• Committee Assignments	Deferred.	
• Response to OAPP's Board Report	Mr. Ballesteros asked if everyone received the survey that he had sent out. He said he had received only one back from the Commission plus a few from the community. He said he would extend the deadline to Friday afternoon. He would spend the weekend compiling responses, then return that to the Commission for finalization. He reminded people that OAPP produced a report to the Board and the Commission was asked to comment on it.	
• Response to A/C Purchase Order Report	Deferred.	
• Public Relations Strategy	Deferred.	
XIV. Announcements	Robert Butler noted that the Second District Coalition/Consumer Advocacy Advisory Board would meet Monday at MAP in Baldwin Hills at Stockard and Santa Rosa at 7:00 p.m. It will be the first of several organizational meetings to help providers and CABs to understand their challenges, rights and responsibilities better, and to work more effectively together. The Second District Coalition meets the second Monday of each month, Mr. Butler added, at Mt. Carmel on 7th and Hoover from 9:00 a.m. to 12:00 noon.	
	Mr. Freehill noted that Governor Davis' budget was due for release the next day. He recommended people review all health care issues.	
	Ricahrd Eastman said he attended Governor Davis' inauguration on Monday and on Saturday had met with him earlier. He noted that he advocated to Governor Davis not to cut the HIV/AIDS budget. Governor Davis responded that he would do the best he could.	
	Mr. Eastman also noted he was trying to put together a medical marijuana task force with Mayor Hahn and Chief Bratton. Sheriff Baca said	

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	he would attend once it was set up. Mr. Eastman asked interested Commissioners to contact him about involvement in the Task Force.	
	Mr. Eastman also noted that on February 16th the Minority AIDS Project is having an event coordinated by Archbishop Carl Bean. The role reversal show, "I Was Born This Way", is the annual fundraiser for MAP and the Unity Fellowship Church. It's $10 in advance, $15 at the door. The doors open at 5:00 p.m. and the show starts at 6:00 p.m.	
	Kay Ostberg, Being Alive Board Member, reiterated the work Being Alive has been doing to develop a "Patients Bill of Rights" for Los Angeles County. There is a 26-member committee involved with development of the needs assessment. She invited interested parties to contact her or any Being Alive Board member.	
XIV. Adjournment	Mr. Land asked the Commission to adjourn in memory of George Vagas, the long-time Public Benefits Administrator at AIDS Service Center, who passed away December 26th. He also acknowledged Carlos Grande who transitioned on December 15th. Mr. Gonzales added two friends, Danny, who died last month of complications of HIV/AIDS, and his friend Willa, whose life support would be discontinued the same day.	
	The meeting adjourned at 2:15 p.m.	

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MOTION AND VOTING SUMMARY		
MOTION #1: Approve the agenda with deletion of three items from the Co-Chairs' Report: Commission Membership Strategy, Latino Caucu/Task Force and the AMASSI Study.	***Consensus***	**Motion passes**
MOTION #2: Approve extension of meeting by 15 minutes.	***Consensus***	**Motion passes**
MOTION #3: Approve the Finance Committee recommendation to renew and extend the contract with Non-Profit Management Solutions (NMS) to conduct the FY 2004 Assessment of the Administrative Mechanism, and to authorize the Executive Committee—in consultation with the Finance Committee—to determine the strategy with which to advocate it to stakeholders.	***Ayes***: Ballesteros, Butler, Carranto, Corian, Eastman, Freehill, Gonzales, Haupert, Henry, Jordan, Land, Ma, Mendia, Palomo, Perry, Talamantes, Van Vreede, West, White Bear Claws, Younai	**Motion passes**
MOTION #4: Approve the Solicitation of Bids for the design and publication of the Comprehensive Care Plan, once revised in March 2003.	***Ayes***: Ballesteros, Butler, Carranto, Corian, Eastman, Freehill, Gonzales, Haupert, Henry, Jordan, Land, Ma, Mendia, Palomo, Perry, Talamantes, Van Vreede, West, White Bear Claws, Younai	**Motion passes**
MOTION #5 : Approve the P&P Committee recommendation to renew and extend the contract with Partnership for Community Health (PCH) for Comprehensive Care Plan revisions, needs assessment, priority- and allocation-setting, and consumer expressed need data collection and analysis work, and to au-	***Ayes***: Ballesteros, Butler, Carranto, Corian, Eastman, Freehill, Gonzales, Haupert, Henry, Jordan, Land, Ma, Mendia, Palomo, Perry, Talamantes, Van Vreede, West, White Bear Claws, Younai	**Motion passes**

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thorize the Executive Committee—in consultation with the P&P Committee—to determine the strategy with which to advocate it to stakeholders.		
MOTION #6: Restart the Commission's public awareness campaign, with a budget determined by the RD&B and Executive Committees.	***Ayes***: Ballesteros, Butler, Carranto, Corian, Eastman, Freehill, Gonzales, Haupert, Jordan, Land, Ma, Mendia, Palomo, Talamantes, Van Vreede, West, White Bear Claws, Younai ***Abstain:*** Henry, Perry	**Motion passes:** 18 ayes, 0 opposed, 2 abstentions
MOTION #7: Approve Summary Report of August 28, 2002.	***Ayes***: Ballesteros, Butler, Carranto, Corian, Eastman, Freehill, Gonzales, Haupert, Henry, Jordan, Land, Ma, Mendia, Palomo, Perry, Talamantes, Van Vreede, West, White Bear Claws, Younai	**Motion passes**
MOTION #8: Approve Summary Report of September 12, 2002.	***Ayes***: Ballesteros, Butler, Carranto, Corian, Eastman, Freehill, Gonzales, Haupert, Henry, Jordan, Land, Ma, Mendia, Palomo, Perry, Talamantes, Van Vreede, West, White Bear Claws, Younai	**Motion passes**
MOTION #9: Approve Summary Report of December 12, 2002.	***Ayes***: Ballesteros, Butler, Carranto, Corian, Eastman, Freehill, Gonzales, Haupert, Henry, Jordan, Land, Ma, Mendia, Palomo, Perry, Talamantes, Van Vreede, West, White Bear Claws, Younai	**Motion passes**